STATE OF ARIZONA
DEPARTMENT OF EMERGENCY AND MILITARY AFFAIRS
DEMA Procurement Office, Building #M5330
5636 East McDowell Road
Phoenix, Arizona 85008-3495.

INVITATION FOR BID NUMBER: M9-0014

BID DUE DATE: 2:00 pm (AZ TIME), March, 3, 2009

In accordance with Arizona Revised Statute §41-2533, competitive sealed Bids for the material or service specified will be received by the Department of Emergency and Military Affairs (hereinafter referred to as Department) Procurement Office (State), location identified above, until the date and time cited. Offers received will be opened and read publicly.

Bids must be in the possession of the Department Procurement Office (State) on, or prior to, the due date and time. Except as provided in the Arizona Procurement Code, late bids will not be considered. Offerors submitting late bids will be so notified.

Bids must be submitted in a sealed envelope with the Invitation for Bid Number and the Offeror's name and address clearly indicated on the envelope. All bids must be completed in ink or be typewritten. Additional instructions for preparing bids are provided herein. Offerors are encouraged to carefully read the entire Solicitation.

People with disabilities may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility. Requests for special accommodations must be made with 72 hours prior notice to the Department of Emergency & Military Affairs Procurement Office.

MATERIAL OR SERVICE: Contractor shall perform a PHYSICAL ASSESSMENT by an examining physician, nurse practitioner or physician assistant (examining professional) licensed to practice medicine in the State of Arizona.

FOR QUESTIONS ON THE SCOPE OF WORK: Dave Costa **TELEPHONE:** (928) 773-3240 dave.costa@campnavajo.com

CONTRACT TYPE: Firm fixed price

CONTRACT TERM: Two (2) years with three (3) one (1) year options to renew

BUYER: Kathy Eastep **TELEPHONE:** (602) 267-2763 kathy.eastep@azdema.gov

BID ISSUE DATE: 2/6/09

Copies via Internet: A copy of the solicitation documents may be downloaded from

http://www.azdema.gov/jp/pc/solicitations.html

CORRY SLAMA
As Procurement Officer and Not Personally

NOTE: Map/Location of the DEMA Procurement Office (State) is on the back of this page

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The **documents and forms listed below in boldface type and underlined** must be completed and returned by the Offeror. Other documents may be required. Offerors should carefully review all sections of the Invitation for Bid.

SECTION I

UNIFORM INSTRUCTIONS TO OFFERORS v 7.1

The State of Arizona's approved Uniform Instructions **(Version 7.1, Dated 05/01/03)** to Offerors/Bidders are incorporated herein by reference and are available for public review and download in Adobe Acrobat format from the following web site:

http://www.azdoa.gov/spo/procurement-documents/procurement-documents

A hardcopy of the State of Arizona's approved Uniform Instructions to Offerors/Bidders is available upon request by visiting the Emergency and Military Affairs Procurement Office (State), 5636 E. McDowell Rd., Building M5330, Phoenix, AZ 85008-3495 or by calling (602) 267-2699.

SECTION II

UNIFORM TERMS AND CONDITIONS – Az SPO Form 202, Revision 7

The State of Arizona's approved Uniform Terms and Conditions **(Version 7.0, Dated 05/01/03)** are incorporated herein by reference and are available for public review and download in Adobe Acrobat format from the following web site:

http://www.azdoa.gov/spo/procurement-documents/procurement-documents

A hardcopy of the State of Arizona's approved Uniform Terms and Conditions is available upon request by visiting the Emergency and Military Affairs Procurement Office (State), 5636 E. McDowell Rd., Building M5330, Phoenix, AZ 85008-3495 or by calling (602) 267-2699.

SECTION III

SPECIAL INSTRUCTIONS TO BIDDERS/OFFERORS

1. **PREPARATION OF BID**

   A. All bids shall be submitted on the forms provided in this solicitation package. Copies of these forms are acceptable, however, telegraphic bids, mailgrams, or bids sent by facsimile will not be considered.

   B. The authorized person signing the Offer shall initial (in ink) all erasures, interlineations, or other modifications in its bid.

   C. Bid prices shall be shown in both words and figures. In case of a discrepancy, the amount in words shall prevail. In the case of a mathematical error in extending the prices in its bid, the State will consider only the unit price. No bidder will be permitted to alter, amend, or withdraw its bid after the specified bid due date and time.

   D. Unless otherwise noted, all time periods listed as number of days shall be considered calendar days.

   E. It is the responsibility of each bidder to examine the complete Solicitation package and seek clarification for any items or requirements that may appear to be incorrect, unclear or ambiguous. All responses shall be thoroughly checked by the respective bidding vendor for accuracy and completeness before submission to the State. Negligence in preparing a bid confers no legal right of withdrawal after the due date and time.

2. **BID PROPOSAL FORM**

For reasons of clarity, all pricing shall be priced for the same unit characteristics (size, volume, quantity, weight, color, etc.) as the bid specifications request unless specifically called for otherwise in the specifications.

Bid pricing must be provided on the price sheet(s) provided in this solicitation. Submissions (bids) failing to comply with this requirement may be declared non-responsive.

3. **DUE DATE/COPIES**

All bids must be marked with the bid number on the outside of the response envelope and be delivered to: Department of Emergency and Military Affairs, 5636 E. McDowell Rd., Building M5330, Phoenix, AZ 85008-3495.

Invitation for Bids require only one (1) original document and no copies.

SECTION IV
DEMA SPECIAL TERMS AND CONDITIONS

1. **EVALUATION**
A Contract shall be awarded to the lowest, responsible, responsive Offeror whose Bid conforms in all material aspects of the requirements and criteria set forth in this Solicitation.

2. **CALENDAR DAYS**
The Offeror shall state, on the Bid Proposal Form, the least number of calendar days (counting Sundays and holidays) after date of receipt of Notice to Proceed in which they will complete performance. The Offeror shall make any allowance for possible difficulties which may be encountered.

3. **SIMILAR WORK**
Each Bidder shall furnish, upon request, a statement of whether they are now, or have ever been, engaged in work similar to that covered by the Solicitation. Such statement shall include the year in which such work was performed, the manner of its execution, and give such other information as will tend to show the Bidder's ability to prosecute the required work.

4. **CONTRACT APPLICABILITY**
The Contractor shall comply with all requirements found within the text of the Contract and this Solicitation. All previous agreements, Contracts, or other documents, which have been executed between the Contractor and the Department are not applicable to this Solicitation nor any resultant Contract.

5. **VALUE IN PROCUREMENT**
Through the Governor's Efficiency Review initiative the Value in Procurement Committee has been established. A major initiative of the VIP Committee is to aggregate specific procurements to increase efficiency and cut costs. The VIP Committee may designate and establish a statewide contract for these types of goods or services. At such time, this contract may not be extended beyond its original term even though additional contract extensions may still be available.

6. **OFFSHORE PERFORMANCE OF WORK PROHIBITED**
Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers. Offerors shall declare all anticipated offshore services in their bid/proposal.

7. **ELECTRONIC AND INFORMATION TECHNOLOGY**
Any electronic or information technology offered to the State of Arizona under this solicitation shall comply with A.R.S. 41-2531 and 2532 and Section 508 of the Rehabilitation Act of 1973, which requires that employees and members of the public shall have access to and use of information technology that is comparable to the access and use by employees and members of the public who are not individuals with disabilities.

8. **FEDERAL IMMIGRATION LAWS, COMPLIANCE BY STATE CONTRACTORS**
By signing the Offer the Offeror warrants that it and all proposed subcontractors are in compliance with the Federal Immigration and Nationality Act (FINA) and all other Federal immigration laws and regulations related to the immigration status of its employees. The Offeror shall obtain statements from all proposed subcontractors certifying compliance with this requirement and shall furnish the statements to the Procurement Officer upon request.

By entering into the Contract, the Contractor warrants compliance with the Federal Immigration and Nationality Act (FINA) and all other Federal immigration laws and regulations related to the immigration status of its employees. The Contractor shall obtain statements from its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer upon request. These warranties shall remain in effect through the term of the Contract. The Contractor and its subcontractors shall also maintain Employment Eligibility Verification forms (I-9) as required by the U.S. Department of Labor's Immigration and Control Act, for all employees performing work under the Contract. I-9 forms are available for download at USCIS.GOV.

The State may request verification of compliance for any Contractor or subcontractor performing work under the Contract. Should the State suspect find or that the Contractor or any of its subcontractors are not in compliance, the State may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance is the responsibility of the Contractor.

9. **COMPLIANCE REQUIREMENTS FOR A.R.S. § 41-4401, GOVERNMENT PROCUREMENT: E-VERIFY REQUIREMENT**. The contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. § 23-214, Subsection A. (That subsection reads: "After December 31, 2007, every employer, after hiring an employee, shall verify the employment eligibility of the employee through the E-Verify program.)

A breach of a warranty regarding compliance with immigration laws and regulations shall be deemed a material breach of the contract and the contractor may be subject to penalties up to and including termination of the contract.

Failure to comply with a State audit process to randomly verify the employment records of contractors and subcontractors shall be deemed a material breach of the contract and the contractor may be subject to penalties up to and including termination of the contract.

The State Agency retains the legal right to inspect the papers of any employee who works on the contract to ensure that the contractor or subcontractor is complying with the warranty under paragraph 1of this subsection #9 in this solicitation.

10. **CONTRACT EXTENSION**
The State reserves the right to unilaterally extend the Contract for thirty-one (31) days past the expiration date. Any resultant Contract may be extended by mutual written agreement for supplemental periods up to a maximum contract term of five (5) years.

11. **NOTICE TO PROCEED**
The Department shall issue a Notice to Proceed or executed Purchase Order for the material or service covered by the Contract. The term of any resultant Contract shall commence on the date of Notice to Proceed or Purchase Order and continue for the period of time indicated in the Contract, unless terminated, canceled or extended as otherwise provided.

12. **CONTRACT TERM**
The term of any resultant Contract shall commence on the date of award and continue for a period of Two (2) years with three (3) one (1) year options to renew thereafter, unless terminated, canceled or extended as otherwise provided herein.

13. **PRICE ADJUSTMENT**
The State may review a fully documented request for a price increase only after the Contract has been in effect for two (2) year(s). A price increase adjustment shall only be considered at the time of a Contract extension and shall be a factor in the extension review process. The State shall determine whether the requested price increase or an alternate option is in the best interest of the State. The price increase adjustment, if approved, will be effective upon the date of the Contract amendment.

14. **PRICE ADJUSTMENT**
A price reduction adjustment may be offered at any time during the term of the Contract and shall become effective upon notice.

15.

INDEMNIFICATION CLAUSE:

Contractor shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the contractor or sub-contractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS

Contractor and subcontractors shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Contract, are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or subcontractors.

The *insurance requirements* herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might arise out of the performance of the work under this contract by the Contractor, its agents, representatives, employees or subcontractors, and Contractor is free to purchase additional insurance.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.
   - General Aggregate $2,000,000
   - Products – Completed Operations Aggregate $1,000,000
   - Personal and Advertising Injury $1,000,000
   - Blanket Contractual Liability – Written and Oral $1,000,000
   - Fire Legal Liability $ 50,000
   - Each Occurrence $1,000,000

   a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".***

   b. Policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

2. **Business Automobile Liability**
   Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of this Contract.

   Combined Single Limit (CSL) $1,000,000

   a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents,***

and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$ 500,000
Disease – Each Employee	$ 500,000
Disease – Policy Limit	$1,000,000

a. Policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

b. This requirement shall not apply to: Separately, EACH contractor or subcontractor exempt under A.R.S. 23-901, AND when such contractor or subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$1,000,000
Annual Aggregate	$2,000,000

In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Contractor warrants that any retroactive date under the policy shall precede the effective date of this Contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract is completed.

The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. ADDITIONAL INSURANCE REQUIREMENTS

The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this Contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this Contract.

C. NOTICE OF CANCELLATION

Each insurance policy required by the insurance provisions of this Contract shall provide the required coverage and shall not be suspended, voided, canceled, or reduced in coverage or in limits except after thirty (30) days prior written notice has been given to the State of Arizona. Such notice shall be sent directly to **Arizona Department of Emergency and Military Affairs, 5636 E. McDowell Rd., Bldg. M5330, Phoenix, AZ 85008.** and shall be sent by certified mail, return receipt requested.

D. ACCEPTABILITY OF INSURERS

Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. VERFICATION OF COVERAGE

The awarded Contractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this Contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

All certificates and endorsements are to be received and approved by the State of Arizona before work

commences. Each insurance policy required by this Contract must be in effect at or prior to commencement of work under this Contract and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this Contract, or to provide evidence of renewal, is a material breach of contract.

All certificates required by this Contract shall be sent directly to **Department of Emergency and Military Affairs, 5636 E. McDowell Rd., Bldg. #M5330, Phoenix, Az. 85008.** The State of Arizona project/contract number and project description shall be noted on the certificate of insurance. The State of Arizona reserves the right to require complete, certified copies of all insurance policies required by this Contract at any time. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT SECTION.**

F. SUBCONTRACTORS

Contractors' certificate(s) shall include all subcontractors as insureds under its policies **or** Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the minimum requirements identified above.

G. APPROVAL

Any modification or variation from the *insurance requirements* in this Contract shall be made by the Department of Administration, Risk Management Section, whose decision shall be final. Such action will not require a formal Contract amendment, but may be made by administrative action.

H. EXCEPTIONS

In the event the Contractor or sub-contractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the contractor or sub-contractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

ATTACHMENT A -- OFFER & ACCEPTANCE DOCUMENT

STATE OF ARIZONA
DEPARTMENT OF EMERGENCY AND MILITARY AFFAIRS
INVITATION FOR BID NUMBER: M9-0014

Submit the ORIGINAL of this attachment to the Department Procurement Office

TO: Procurement Manager, Department Procurement Office (State)

The Undersigned hereby offers and agrees to furnish the construction in compliance with all terms, conditions, drawings, specifications and addenda. By signing this attachment the undersigned also understands and will comply with the Instructions to Offerors. Furthermore, in accordance with A.R.S. § 35-397, the offeror hereby certifies that the offeror does not have scrutinized business operations in Iran and/or Sudan.

Arizona Transaction (Sales) Privilege Tax License No.:		Point of contact for questions concerning this offer:
Federal Employer Identification No.:		Name:
Commercial Contractor's License No:		Telephone No.:
Company Information:		Fax No.:
Company Name:		Email Address:
Street Address		Authorized signature:
Street Address		Printed Name:
City State Zip		Title
Company Email Address:		Signature

ACCEPTANCE OF OFFER AND CONTRACT AWARD

When signed below, your Bid is hereby accepted. The Contractor is now bound to perform based upon the solicitation and the Contractor's bid as accepted by the State. This Contract shall be referenced by Contract No. **M9-0014 You are cautioned not to commence any billable work or provide materials/services under this Contract until having received an executed Purchase Order or Notice to Proceed letter.**

AZ. DEPT. OF EMERG. & MILIARY AFFAIRS

Awarded the _____ day of _____, **200**___

_____
Corry Slama, C.P.M., CPPB
As Procurement Manager & Not Personally

ATTACHMENT B

BID PROPOSAL FORM

M9-0014

Sealed Bids will be received until **2:00 pm (AZ TIME), March 3, 2009**, in the Department Procurement Office (State), Building #M5330, 5636 East McDowell Road, Phoenix, Arizona 85008-3495. Bids will be opened in Building #M5330.

Having carefully examined the premises and conditions affecting this work, the Offeror proposes to provide all labor, supplies, material, applicable taxes, transportation, and services required to complete a PHYSICAL ASSESSMENT by an examining physician, nurse practitioner or physician assistant (examining professional) licensed to practice medicine in the State of Arizona.

In accordance with the specifications and **Scope of Work,** provide a **FIRM FIXED** price for the following:

1. General Physical and Musculoskeletal Examination (Exam) EACH $_____
2. Respirator Clearance, including completion of all forms, **with exam** EACH $_____
3. Vision Screen WITHOUT exam EACH $_____
4. USDOT/CDL Physical Exam Re-Certification EACH $_____
5. Liver enzyme blood panel EACH $_____
6. Pulmonary Function Test (FVC, FEV1 & FVC/FEV1 ratio) EACH $_____

PAYMENT TERMS:

Net _____ Days or Prices quoted herein can be discounted by _____% if payment is made within _____ days of invoice receipt.

The Offeror is familiar with all the provisions of this Solicitation, local conditions and has carefully checked the figures comprising his bid.

The Department of Emergency and Military Affairs is not be responsible for any errors or omissions on the part of the Offeror.

This bid may not be withdrawn for a period of ninety (90) days after the bid opening date.

ATTACHMENT C
CERTIFICATE OF CORPORATE AUTHORITY

Offerors must provide the following information:

A Corporation existing under the laws of the State of _____; or

A Partnership consisting of _____; or

An Individual trading as _____.

If your firm is a corporation, completion of the following certification is mandatory. **(NOTE:** THE CERTIFICATE MUST BE COMPLETED BY AN OFFICER OF THE CORPORATION AND WHO DID NOT SIGN THE OFFER PAGE).

I, _____, certify that I am the _____ of the Corporation named as Offeror herein; that _____ signed this Bid on behalf of the Corporation, was then the _____ of said Corporation; that said Bid was duly signed for and in behalf of said Corporation by authority of its governing body, and is within the scope of its corporate powers.

_____
CORPORATE OFFICER
(Signature)

ATTACHMENT D
NON-COLLUSION AFFIDAVIT

STATE OF ARIZONA)
)
COUNTY OF _____)

_____, Affiant,_____
(Name) (Title)

Of _____, the Person, Corporation, or Company
(Firm Name)

Who makes the accompanying Bid, having first been sworn, deposes and says:

> "That such Bid is genuine and is not sham or collusive, or made in the interest or behalf of any person not herein named, and that the Offeror has not directly or indirectly induced or solicited any other Offeror to put in a sham Bid, or any other Person, Firm or Corporation to refrain from bidding, and that the Offeror has not in any manner sought by collusion to secure for itself an advantage over any other Offeror."

_____
(Firm Name)

By: _____

_____
(Title)

Subscribed and sworn to before me this _____ day of _____, 20___.

My Commission Expires:_____ _____
(Date) (Notary Public)

ATTACHMENT E

SUSPENSION/DEBARMENT AFFIDAVIT

(Required only for offers over $100,000)

STATE OF ARIZONA)
)
COUNTY OF _____)

_____, Affiant,_____
(Name) (Title)

of _____, the Person, Corporation, or Company who make the accompanying
(Firm Name)

Bid, having first been sworn, deposes and says:

"That the Firm, Business or person submitting an offer is not debarred, suspended or otherwise lawfully precluded from participating in any public procurement activity, including being disapproved as a subcontractor with any Federal, State or local government.

It is agreed that if any such preclusion from participation from any public procurement activity is currently pending, the Offeror must fully explain the circumstances relating to the preclusion or proposed preclusion. If awarded, the offeror must include a letter with its offer setting forth the name and address of the governmental unit, the effective date of this suspension or debarment, the duration of the suspension of debarment, and the relevant circumstances relating to the suspension or debarment. If suspension or debarment is currently pending, a detailed description of all relevant circumstances including the details enumerated above must be provided."

_____
(Firm Name)

By:_____
(Signature)

_____
(Title)

Subscribed and sworn to before me this _____ day of _____, 20___.

My Commission Expires:_____ _____
(Date) (Notary Public)

ATTACHMENT F

SMALL, WOMAN-OWNED AND/OR MINORITY-OWNED BUSINESS CERTIFICATION

Executive Order 2004-29 requires all State of Arizona agencies to track and report solicitations distributed and awarded to Small, Woman-Owned and/or Minority-Owned firms.

A small business is one that, including its affiliates, is independently owned and operated, is not dominant in the type of business it conducts, and employs fewer than 100 employees OR has less than $4 million in annual sales. To qualify as a minority or women-owned business, the firm must be at least 51% minority or woman owned.

When practical, purchases/contracts less than $50,000 will be made from small businesses.

CHECK THE APPROPRIATE CLASSIFICATION APPLICABLE TO YOUR FIRM:

○ 1.0 Small Business (SB) ○ 2.0 Small Business- African American (SBAA) ○ 3.0 Small Business- Asian (SBA) ○ 4.0 Small Business- Hispanic (SBH) ○ 5.0 Small Business- Native American (SBNA) ○ 6.0 Small Business- Other (SBO) ○ 7.0 Small, Woman Owned Bus. (SWOB) ○ 8.0 Small, Woman Owned Bus.- African American (SWOBAA) ○ 9.0 Small, Woman Owned Bus.- Asian (SWOBA) ○ 10.0 Small, Woman Owned Bus. Hispanic (SWOBH) ○ 11.0 Small, Woman Owned Bus. Native American (SWOBNA) ○ 12.0 Small, Woman Owned Bus. Other (SWOBO)	○ 13.0 Woman Owned Business (WOB) ○ 14.0 Woman Owned Bus. African American (WOBAA) ○ 15.0 Woman Owned Bus. Asian (WOBA) ○ 16.0 Woman Owned Bus. Hispanic (WOBH) ○ 17.0 Woman Owned Bus. Native American (WOBNA) ○ 18.0 Woman Owned Bus. Other (WOBO) ○ 19.0 Minority Owned Bus. African American (MAA) ○ 20.0 Minority Owned Bus. Asian (MA) ○ 21.0 Minority Owned Bus. Hispanic (MHA) ○ 22.0 Minority Owned Bus. Native American (NA) ○ 23.0 Minority Owned Bus. Other (MO)
□ 24.00 (NONE) None of these categories is applicable and firm does not qualify as either a Small, Woman, or Minority-Owned firm.	

==========

Company Name: _____

Address: _____

City:_____ State: _____ Zip Code _____

I hereby certify that _____ (Firm/Company Name) □**is** or □**is not** (check one) a small business with less than 100 employees and/or less than $4 million in annual sales.

_____ _____
Signature Date

I hereby certify that _____ (Firm/Company Name) □**is** or □**is not** (check one) a □ Minority and/or □ Women (check one or both) Owned Business in accordance with Executive Order 2004-29 issued by Governor Napolitano.

_____ _____
Signature Date

EXHIBIT 1
SCOPE OF WORK

EXHIBIT ONE
SCOPE OF WORK

1.0 REQUIREMENTS

1.1. Contractor shall perform a PHYSICAL ASSESSMENT **by an examining physician, nurse practitioner or physician assistant (examining professional) licensed to practice medicine in the State of Arizona.**

The Physical Assessment shall include all items listed on Exhibit two of this solicitation.

(PROVIDER MUST BE WITHIN 25 MILES (DRIVING DISTANCE) OF BELLEMONT, AZ)

1.1.1. Assessment of general appearance, head, ears (including otoscopic examination), nose, mouth/throat, neck, lymphatic, chest, heart, abdomen, pulses, skin, mental status, reflexes and sensory status.

1.1.2. Tests shall include at a minimum:

1.1.2.1. Rule out hernia
1.1.2.2. Phalen's Test
1.1.2.3. Tinel's Test
1.1.2.4. Thenar/hypothenar atrophy

1.1.3. Thorough musculoskeletal evaluation including:

1.1.3.1. Spine
1.1.3.2. Standing posture
1.1.3.3. Gait
1.1.3.4. Range of motion
1.1.3.5. Strength of upper and lower extremities, neck and trunk
1.1.3.6. Grip strength
1.1.3.7. Balance
1.1.3.8. Squats/rises
1.1.3.9. Kneeling

1.1.4. The **examining professional** shall review, assess, discuss with the individual (if necessary), note comments **and initial** each section of the exam as indicated the following items:

1.1.4.1 Personal (general) medical/health history
1.1.4.2 Immunization history
1.1.4.3 Lifestyle history/habits
1.1.4.4 Family health history

1.1.4.5 Past employment health history

1.1.5. **The examining professional** shall review and initial the Pulmonary Function Test, if one was done.

1.1.6. The **examining professional** shall ensure a **USDOT Commercial Driver License** form is properly completed and signed as required at the time the exam is completed, if appropriate to the exam.

2.0 PARAPROFESSIONAL MEDICAL PERSONNEL TESTING

2.1. Testing that may be done by paraprofessional clinic personnel (Exhibit 2, Exam) are as follows:

2.1.1. Height, weight, vital signs
2.1.2. Dip-stick urinalysis
2.1.3. A vision test that includes:

2.1.3.1. Visual acuity, near and distant.
2.1.3.2. Visual field
2.1.3.3. Color discrimination
2.1.3.4. Depth perception

2.1.4. The paraprofessional clinic personnel may also perform the following (as may be required by a specific exam):

2.1.4.1. Pulmonary Function Test (FVC, FEV1 and FVC/FEV1 ratio)

2.1.4.2. Lab work: a liver enzyme panel that includes: GGTP, alkaline phosphatase, LDH, AST, ALT, total bilirubin.

ALL EXAMS MUST CONFORM TO STANDARDS SET IN 49 CFR SUBPART E, SECTIONS 391.41 THRU 391.49

3.0 PHYSICAL ASSESSMENT REPORTING

3.1. The **examining professional** shall report the individual's medical condition, by mailing a written copy of the report (with Recommendations for Employment), to the State of Arizona, Department of Emergency and Military Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ, 86015. Any pre-existing medical conditions shall be noted appropriately on the report.

3.2. The examining professional will use the attached Medical Exam Form to report the medical conditions.

3.3. If the examining professional discovers any health problems or abnormal findings, s/he shall immediately mail a written copy of the findings to: ADOA Occupational Health

Services, 100 N. 15th Avenue, Suite 301, Attn Mira Dobson. All findings shall be thoroughly documented on **forms provided by the State of Arizona.**

3.4. When applicable to exam, contractor shall perform a physical assessment to determine the individual's ability to use a **respirator.** The assessment shall include, but not limited to, the following:

3.4.1. Assessment of the head, neck, throat, mouth, lungs, heart, abdomen, and vital signs.
3.4.2. Review and discuss with the individual his/her history as disclosed on forms provided by the requesting agency.
3.4.3. Perform and evaluate a Pulmonary Function Test (FVC, FEV1 & FVC/FEV1 ratio).
3.4.4. Following the completion of the individual's physical assessment and review of health history and PFT, the contractor, using appropriate forms, must provide to the State of Arizona, Department of Emergency and Military Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ 86015, a written statement of the individual's ability to use a respirator.

3.5. The contractor must use forms that the State of Arizona Department of Emergency and Military Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ 86015 provides (see attached forms). All exams shall include review of questionnaire and physical examinations that shall include:

3.5.1. General assessment, head, ears, nose, mouth/throat, neck, lymphatic, chest, heart, abdomen, pulses, skin, hernia neurological, musculoskeletal.
3.5.2. Tests for near and distant vision, peripheral vision, depth perception and color discrimination
3.5.3. Height, weight and vital signs
3.5.4. Dipstick urinalysis
3.5.5. OSHA approved audiogram
3.5.6 Pulmonary Function Test (FVC, FEV1 and FVC/FEV1 ratio) including completed respirator clearance form.
3.5.7. Physician's review of questionnaire and physical examination.
3.5.8. When specialized tests are required, the State Agency will notify the contractor of such tests to be performed.
3.5.9 Following the completion of the individual's physical assessment and review of history and test results, the contractor must provide a written statement indicating any evidence of asbestos exposure health problems using appropriate forms.

4.0 The examining professional shall prepare the Medical Examiners Report for all individuals for which a USDOT (CDL License) is involved.

The contractor shall send the original USDOT exam and card to the Arizona Department of Emergency

and Military Affairs. The Card shall be sent to the State of Arizona Department of Emergency and Military Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ, 86015.

5.0 GENERAL REQUIREMENTS

5.1 The contractor must be able to accommodate appointments for candidates within **three (3) working days** of the initial request for an appointment.

5.2 Within one **(1) working day** following completion of exams not requiring lab work or x-rays, Exam report results shall be mailed to the State of Arizona Department of Emergency and Military Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ, 86015. Lab, urine and x-ray results shall be mailed within three **(3) working days**.

5.3 All **original** State Agency forms shall be returned within **three (3) working days** of completion of the exam by mail (marked **CONFIDENTIAL)** to the State of Arizona Department of Emergency and Military Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ 86015. The contractor shall send, by mail, to The State of Arizona Department of Emergency and Mililtary Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ, the original test documents of the audiogram and pulmonary function test, if one was done. The contractor shall keep one copy of test documents and completed form(s) for their records. All copies are confidential and the contents of such may not be released except upon written consent of the State of Arizona, Department of Emergency and Military Affairs, Camp Navajo Garrison Command, PO Box 16123, Bellemont AZ, 86015. Data obtained by the contractor through the course of these examinations may be used only in aggregate form and may not identify either individuals, (by name, age, gender, race, color or national origin) or groups of persons as candidates for employment or employed individuals within the State of Arizona.

6.0 BILLING/INVOICES

All billing and invoices for services covered under this solicitation shall be sent to: CAMP NAVAJO GARRISON COMMAND, PO BOX 16123 BELLEMONT AZ, 86015.

EXHIBIT 2 Health History & Physical Examination Form - attached.

CONFIDENTIAL

HEALTH HISTORY & PHYSICAL EXAMINATION FORM

Arizona Department of Emergency and Military Affairs

CAMP NAVAJO GARRISON COMMAND

P.O. Box 16123, Bellemont Arizona 86015

CLINIC PERSONNEL: PICTURE ID CHECK _____ (initials) **DATE OF EXAM: _____**

PATIENT please complete this health history form, pages 1-7 only. Answer all questions. PLEASE PRINT LEGIBLY.

NAME: (Last First)		BIRTHDATE:		SEX: M F
ADDRESS:			SOC. SEC. NO.:	
CITY:	STATE:	ZIP:	PHONE:	
ETHNICITY: (circle one) Asian	African American	Caucasian	Hispanic	Native American Other
JOB APPLIED FOR:		STATE AGENCY:		

PERSONAL HEALTH HISTORY ***If you do not understand any question/item pages 1-7, please ask clinic personnel for assistance.***

Are you allergic to any medications? Y N If yes, what? _____ What happens to you when you take it? _____ Other allergies: _____

Are you currently under a doctor's care? Y N If yes, for what reason? _____

Are you taking any medicines? Y *N*

(If yes, list all prescription and over-the-counter medicine you are taking ***including herbals/supplements)****:*

Name of medicine	Reason	Doctor's name

Do any of the above medications make you drowsy or sleepy? ___ Y ___ N

PHYSICIAN REVIEW/comments: _____

PHYSICIAN INITIALS _____

Have you ever had surgery? Y N If yes, list **all** surgery dates and type of surgery.

_____

_____

_____

PHYSICIAN REVIEW/comments: _____

_____

PHYSICIAN INITIALS_____

CONFIDENTIAL
HEALTH HISTORY & PHYSICAL EXAMINATION FORM
Arizona Department of Emergency and Military Affairs
CAMP NAVAJO GARRISON COMMAND
P.O. Box 16123, Bellemont Arizona 86015

PATIENT LAST NAME: _____

Have you ever been hospitalized? ___ Y ___ N If YES, list **all** dates and reason for admission:

_____

_____

_____

PHYSICIAN REVIEW/comments: _____

_____

PHYSICIAN INITIALS: _____

PLEASE CIRCLE YES OR NO if you **have now or ever had** any of the following. If yes, give **DATES AND DETAILS.**

Y N	chest pains	Y N	heart murmur	Y N	high blood pressure	Y N	congestive heart failure
Y N	diseases of arteries or veins	Y N	heart surgery	Y N	high cholesterol	Y N	abnormal electrocardiogram
Y N	heart attack	Y N	heart trouble	Y N	stroke	Y N	other (explain below)
Y N	take heart medicine	Y N	anxiety	Y N	born with a heart defect or condition		

Explain "yes" answers: _____

_____

PHYSICIAN REVIEW/comments: _____

_____

PHYSICIAN INITIALS _____

Y N	allergies	Y N	emphysema	Y N	shortness of breath
Y N	asthma	Y N	lung surgery	Y N	tuberculosis
Y N	chronic or severe bronchitis	Y N	other lung or breathing problems	Y N	valley fever
Y N	chronic or severe cough	Y N	abnormal chest x-ray	Y N	other (explain below)
Y N	use an inhaler or a breathing machine			Y N	use a CPAP machine

Explain "yes" answers: _____

_____

PHYSICIAN REVIEW/comments: _____

_____

PHYSICIAN INITIALS _____

Y N	eye or vision problems	Y N	wear contact lenses	Y N	hearing or ear problems	Y N	difficulty hearing or understanding speech
Y N	eye surgery	Y N	wear prescription glasses	Y N	ringing in ears		
Y N	glaucoma	Y N	wear reading glasses	Y N	wear hearing aids	Y N	ear surgery
Y N	cataracts	Y N	color blind	Y N	problem with depth perception	Y N	other (list below)

Explain "yes" answers: _____

PATIENT LAST NAME: _____

PHYSICIAN REVIEW/comments:

_____

_____

PHYSICIAN INITIALS _____

Y N	dizziness or fainting spells	Y N	neck pain or problems	Y N	numbness or tingling in hands, arms, legs or feet
Y N	epilepsy or seizures	Y N	memory loss	Y N	treatment for alcohol or drug dependency
Y N	take seizure medication	Y N	mental illness	Y N	other (explain below)
Y N	head or spine injury	Y N	nervous or emotional problems	Y N	problems keeping your balance
Y N	whiplash	Y N	neurological problems or disorder		
Y N	headaches	Y N	trouble climbing stairs		
Y N	schizophrenia	Y N	thoughts of harming self or others		
Y N	depression or mania	Y N	delusions or hallucinations		

Explain "yes"answers: _____

_____

PHYSICIAN REVIEW/comments: _____

_____

PHYSICIAN INITIALS _____

Y N	back pain	Y N	shoulder problems/surgery	Y N	muscle disorders/problems
Y N	sciatica	Y N	wrist/hand problems or surgery	Y N	arthritis or rheumatism
Y N	frequent or chronic back pain	Y N	numbness or tingling in hands/fingers	Y N	bursitis
Y N	back injury	Y N	carpal tunnel syndrome	Y N	osteoporosis
Y N	back surgery	Y N	hip problems or surgery	Y N	phlebitis
Y N	disc problems in back	Y N	knee problems or surgery	Y N	tendonitis
Y N	lifting restriction/problems	Y N	ankle/foot problems or surgery	Y N	joint problems
Y N	pain in buttocks or legs	Y N	difficulty running	Y N	joint surgery
Y N	limited or restricted motion	Y N	poor circulation in legs or feet	Y N	broken bones
Y N	DVT (blood clots)	Y N	injury to muscles, ligaments or tendons	Y N	inability to form a fist
Y N	elbow problems or surgery	Y N	inability to fully open up palm of hands	Y N	other (explain below)

Explain "yes" answers:

_____

_____

PHYSICIAN REVIEW/comments: _____

_____

PHYSICIAN INITIALS _____

PATIENT LAST NAME: _____

Y N	trouble swallowing	Y N	colitis or other bowel disease	Y N	blood or pus in urine
Y N	frequent heartburn	Y N	bladder trouble	Y N	sugar in urine
Y N	ulcers or stomach trouble	Y N	prostate problems	Y N	rectal bleeding
Y N	liver problems	Y N	urinary tract infection	Y N	hemorrhoids
Y N	hepatitis or jaundice	Y N	kidney problems or stones	Y N	gall bladder problems or surgery
Y N	hernia (any type)	Y N	other (explain below)		

Explain "yes" answers: _____

PHYSICIAN REVIEW/comments: _____

_____

PHYSICIAN INITIALS _____

Y N	anemia	Y N	skin problems	Y N	phlebitis
Y N	cancer	Y N	measles or mumps	Y N	rheumatic fever
Y N	diabetes	Y N	meningitis	Y N	thyroid trouble
Y N	low or high blood sugar	Y N	other gland problems	Y N	fibromyalgia
Y N	eczema	Y N	lupus	Y N	other (list below)
Y N	blood disease	Y N	infectious disease		

Explain "yes" answers: _____

_____

PHYSICIAN REVIEW/comments: _____

_____

_____

PHYSICIAN INITITALS _____

Female patients only:

Y N menstrual problems Y N pregnant now Last menstrual period: _____

Comments if "yes": _____

PHYSICIAN REVIEW/comments: _____

PHYSICIAN INITIALS _____

IMMUNIZATION HISTORY

Have you ever had a TB skin test? Y N If yes, when was the most recent (year): _____
Results: Neg _____ Pos _____
If positive, did you have a chest x-ray? Y N If yes, when (year): _____ Results: Neg _____ Pos _____
If positive, did you take medication? Y N What did you take? _____
For how long did you take it? _____

CONFIDENTIAL

HEALTH HISTORY & PHYSICAL EXAMINATION FORM

Arizona Department Emergency and Military Affairs

CAMP NAVAJO GARRISON COMMAND

P.O. Box 16123, Bellemont Arizona, 86015

PATIENT LAST NAME: _____

Mark an X next to those immunizations you have had, and indicate the year.

		What Year	(Circle one)
_____	Tetanus/diphtheria	_____	**Y N Don't know**
_____	MMR (measles, mumps, rubella – German measle)s	_____	**Y N Don't know**
_____	Hepatitis B series (Complete series of all 3 shots)	_____	**Y N Don't know**

LIFESTYLE HISTORY

Do you currently smoke?: Y N What do you smoke?: cigarettes _____ cigars _____ pipe _____

Amount per day: # cigarettes _____ **(OR)** # packs _____ For how many years? _____

Do you currently chew tobacco? Y N amount per day: _____ For how many years? _____

If you do not currently smoke or chew tobacco, have you **ever** smoked? Y N **and/or** chewed tobacco? Y N
For how many years ? _____ How many years since you stopped? _____

How many alcoholic drinks do you average per day? _____

How many caffeinated drinks (coffee,tea,cola) do you average per day? _____

Do you take drugs any other than those listed on page 1? Y N If so, what? _____

Do you exercise regularly? Y N If yes, what kind of exercise? _____

How often? _____ For how many minutes? _____

Do you always wear seat belts while in a motor vehicle? Y N Do you use sunscreen when in the sun? Y N

How would you rate your overall health? _____ What would you like to improve? _____

FAMILY HISTORY: **Has anyone in your immediate family (parents or siblings only) ever had:**

		Who
Y N	alcohol/drug problems	_____
Y N	asthma	_____
Y N	arthritis	_____
Y N	cancer	_____
Y N	diabetes	_____
Y N	glaucoma	_____
Y N	heart attack	_____
Y N	heart disease	_____
Y N	high blood pressure	_____
Y N	mental illness	_____
Y N	stroke	_____

	Age now	General Health
Father		
Mother		
Brother(s)		
Sister(s)		

PAST EMPLOYMENT HEALTH HISTORY Have you worked around (for-pay work, military service, or hobbies):

Y N	asbestos/silica	Y N	extreme heat/cold	Y N	excessive sunlight (outdoors all day)
Y N	computer monitor	Y N	formaldehyde	Y N	vapors/gasses/fumes
Y N	degreasers	Y N	infectious agents	Y N	vibration (ex: jackhammer)
Y N	dust or pollen	Y N	loud noise	Y N	radiation
Y N	ethylene oxide	Y N	solvents/chemicals	Y N	pesticides

Other: _____

Any adverse reactions to exposures? Y N If yes, explain: _____

CONFIDENTIAL
HEALTH HISTORY & PHYSICAL EXAMINATION FORM
Arizona Department Emergency and Military Affairs
CAMP NAVAJO GARRISON COMMAND
P.O. Box 16123, Bellemont Arizona, 86015

PATIENT LAST NAME: _____

Have you ever filed a worker's compensation claim? Y N If yes, provide dates/details:

_____

Are you being treated for an on-the-job injury **now**? Y N If yes, explain:

_____

Do you have an open worker's compensation claim **now**? Y N If yes, explain:

_____

Have you ever lost work time for a work-related illness or injury? Y N If yes, list dates and type of injury:

_____

Do you have any medical, psychological or emotional issues not already mentioned? Y N If yes, please explain:

_____

Are you in any way physically or mentally disabled? Y N If yes, please describe any limitations: _____

If yes, please describe accommodations you may need in order to perform the essential functions of the job you have applied for.

_____

Are you now or have you ever been on any work restrictions or temporary disability due to a **non**-work-related illness/injury? Y N
If yes, list date of injury, type of injury and work restrictions: _____

Have you ever had, or do you now have:

Y N Recent weight loss : amount: _____ lbs.
Y N Recent weight gain: amount: _____ lbs.
Y N Blood transfusions
Y N Blood clotting problems/bleeding disorders
Y N Nervous breakdown: hospitalized? Y N
Y N Tremors, shaking
Y N Latex allergy
Y N Paralysis
Y N Permanent eye trouble not correctable with glasses
Y N Problems with lifting, bending, stooping, or squatting
Y N Chiropractic treatment
Y N Swollen glands
Y N Skull fracture or concussion
Y N Breast disease: What type? _____
Y N Take blood thinning medication
Y N Problems with knees or with kneeling
Y N Mental illness requiring counseling , medication or hospitalization
Y N Neck or back injury or illness requiring x-rays or physical therapy
Y N Dislocation of any joint
Y N Swollen or painful joints
Y N Problems sitting or standing for long periods
Y N Neck lumps or swelling
Y N Angina pectoris for which you take nitroglycerine
Y N Swelling of feet or ankles
Y N Varicose veins
Y N Loss of sense of smell or taste
Y N Hay fever requiring medicine or shots
Y N Narcolepsy
Y N Sleep apnea Do you use a CPAP machine? Y N
Y N Claustrophobia
Y N Has anyone ever issued you a DOT/CDL card for **less than 2 years**? If yes, why?

PHYSICIAN REVIEW/comments:

_____

_____

PHYSICIAN INITIALS: _____

CANDIDATE LAST NAME: _____

PATIENT: PLEASE READ THE AGREEMENT BELOW
SIGN AND DATE WHERE INDICATED

I certify that my answers are true and complete. **I am aware that any falsification of facts presented in this health history form may result in my being disqualified for employment.** I authorize the examining physician to disclose to the State of Arizona Department of Emergency and Military Affairs, Camp Navajo Garrison Command, all information learned and findings made by the physician in the course of this examination. This information may be mailed to Camp Navajo Garrison Command. I understand that these records will remain confidential except as otherwise provided. In consenting to this disclosure I acknowledge that Camp Navajo Garrison Command may utilize this information in determining whether I am able to perform the essential functions of the job for which I have applied. This information may also be provided by Camp Navajo Garrison Command, and utilized in a suspension or revocation action by any State regulatory agency that has issued me a license, in order to prevent or lessen a threat to my health and safety or that of the public. The State of Arizona will not condition enrollment or eligibility for benefits on the signing of this authorization. However, refusing to sign or revoking this authorization may disqualify me for employment. I understand that as the information to be disclosed may be subject to re-disclosure in accordance with this authorization, it may no longer be protected once it is disclosed. The State will not receive remuneration (direct or indirect) from a third party as a result of the use or disclosure of information under this authorization. This authorization expires 90 days after the date on which it is signed. I may revoke my authorization in writing (unless Camp Navajo Garrison Command has taken action on this authorization); such revocation will be effective when a signed statement revoking my authorization is received by Camp Navajo Garrison Command at the address listed at the top of this form.

Date: _____ **Signed:** _____

STOP HERE!

FOR CLINIC USE ONLY

PATIENT LAST NAME: _____

Height. _____ Weight. _____ / BMI _____ Temp. _____ Pulse _____ B/P _____

Dipstick U/A: Glucose _____ (**NOT** specific gravity)
Protein _____
Blood _____ Females only – if blood present, on menses? Y N

EXAMINER'S SIGNATURE: _____ **Date:** _____

Vision: **If candidate wears contact lenses, test with contacts only. Do not have candidate remove contacts for further testing.**

	Tested with glasses or contact lenses			Tested without glasses or contact lens (only if does not wear them)		
Far	R 20/____	L 20/____	Both 20/____	R 20/____	L 20/____	Both 20/____
Near	R 20/____	L 20/____	Both 20/____	R 20/____	L 20/____	Both 20/____

Color _____
Depth _____
Peripheral **R** _____ **L** _____

EXAMINER'S SIGNATURE: _____ **Date:** _____

Audiogram:

	500	1000	2000	3000	4000	6000	8000
Left							
Right							

EXAMINER'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN REVIEW OF PFT RESULTS (IF APPLICABLE TO THIS EXAM)

Physician comments/initials

_____

ATTACH AUDIOGRAM STRIP HERE

FOR CLINIC USE ONLY

CANDIDATE LAST NAME: _____

Normal	Abnormal	PHYSICIAN PHYSICAL ASSESSMENT PLEASE INITIAL APPROPRIATE BOX FOR EACH AREA SYSTEM FINDINGS
		General Appearance.
		Head
		Ears
		Nose
		Mouth/Throat
		Neck
		Lymphatic
		Chest
		Heart
		Abdomen
		Pulses
		Skin
		HERNIA – *EVERY candidate, both male and female, must have all 4 hernia evaluations* Femoral Y N Inguinal Y N Umbilical Y N Ventral Y N COMMENTS:
		EVERY CANDIDATE MUST HAVE BOTH A PHALEN'S TEST AND A TINEL'S TEST **PHALEN'S TEST (2 MINUTES) Positive** _____ **Negative** _____
		TINEL'S TEST Positive _____ **Negative** _____
		Check for thenar/hypothenar atrophy R _____ L _____
		Neurological: Mental Status: _____ Reflexes: _____ Sensory: _____

Additional Comments: _____

PATIENT LAST NAME: _____

MUSCULOSKELETAL EVALUATION

Spine _____

Standing Posture (note any significant findings) _____

Gait _____

Range of Motion (note any significant findings; active measurement only if not within normal limits)

Upper extremities: _____

Lower extremities: _____

Neck: _____

Shoulders: _____

Back:

Forward bending: _____

Backward bending: _____

Lateral bending: _____

SLRT Sitting R_____ L_____ Supine R_____ L_____
(Straight Leg Raising Test)

Strength (note any significant findings) (5=normal 4=good 3=fair 2=poor 1=trace)

Upper Extremities: _____

Biceps: _____

Triceps: _____

Lower extremities: _____

Extensor Hallus Longus (EHL): _____

Trunk: _____

PHYSICIAN INITIALS _____

PATIENT LAST NAME: _____

Grip strength: (Circle one) R L dominant

Right: _____ Left: _____

Comments: _____

_____

Balance: Romberg: _____ Finger to nose: _____

Comments: _____

_____

_____

Squats/Rises (Ask patient to do 5 full squats)

____Full ____Number completed ____Partial (if unable to do full) ____Number completed

Comments: (If candidate is unable to perform full squats, please describe specifically what candidate was able to do and what prevented him/her from doing full squats.)

_____

_____

Kneeling ("Standard": 1 full minute on knees w/ lower legs at 90 degree angle to body). If patient is unable to do full kneel on both knees for 1 full minute, do a "modified" kneel – one knee at a time, 1 minute each. Please document all findings in "Comments" below. If the candidate is unable to perform , please indicate the reason.

_____Standard _____Modified (describe how)

Comments: _____

_____

_____

PHYSICIAN INITIALS _____

CONFIDENTIAL
HEALTH HISTORY & PHYSICAL EXAMINATION FORM
Arizona Department of Emergency and Military Affairs
CAMP NAVAJO GARRISON COMMAND
P.O. Box 16123, Bellemont Arizona, 86015

PATIENT'S NAME: _____

JOB APPLIED FOR: _____

PROVIDER'S RECOMMENDATIONS

Please add pages if you do not have enough room in the spaces provided.

_____ No restrictions

_____ Recommend the following restriction(s) **PLEASE BE SPECIFIC**

_____

_____

_____ Temporarily deferred for the following reasons – **PLEASE BE SPECIFIC**, e.g., "elevated blood sugar, per OHS policy":

_____

_____

Provider's signature: _____ **Date:** _____

PRINT LEGIBLY or STAMP provider's name/credentials: _____ **(Must be completed)**

Address: _____

City/State: _____

Phone: _____

Please return this form, marked CONFIDENTIAL to:

Camp Navajo Garrison Command
P.P. Box 16123
Bellemont Arizona, 86015

FOR OCCUPATIONAL HEALTH SERVICES USE ONLY

Faxed copy of record reviewed by: _____ Date: _____

Original record reviewed by: _____ Date: _____